Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON PAIN & INJURY
604 PENNY LANE
FRIENDSWOOD TEXAS 77546

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
METROPOLITAN TRANSIT AUTHORITY

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-1670-01

MFDR Date Received
December 13, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Documentation supports this level of service."

Amount in Dispute: $984.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Both CPT codes 97110 and 97140 are defined as an 'each 15 minutes' code. According to Centers for Medicare and Medicaid (CMS), payment policies relating to coding, billing, and reporting, 20 minutes allow for 1 unit, 25 minutes allow for 2 units. The disputed units of 97110 and 97140 were denied with an ANSI reduction code of 16. The respondent maintains its position that one unit per day of 97110 was reimbursed correctly, for service dates 9/21/10 to 9/30/10. For service date 10/4/19, two units of 97110 was reimbursed correctly in accordance with the TDI-DWC rule 134.203. It is noted that the requestor, Amber Newell for Houston Pain & Injury Clinic, has sent to Metropolitan Transit Authority, via First Class Mail, the same documentation with an addition of time to the notes. Ms. Newell states this documentation has also been submitted to TDI-DWC, MFDR Division as well. This documentation was received on 2/22/11. This documentation now reflects 'In and Out times' on Houston Pain & Injury Clinic's exercise logs. It is felt that this documentation should not be reviewed at this point. The provider should have corrected the documentation before reconsideration as well as before filing Medical Fee Dispute Resolution. The carrier as well as TDI-DWC has already incurred time in responding to this requestor's original submissions."

Response Submitted by: STARR Comprehensive Solutions, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 21, 2010, September 23, 2010, September 24, 2010, September 28, 2010, September 30, 2010 and October 4, 2010	97140 and 97110	$984.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 18, 2010, October 25, 2010
   - 16 – Documentation does not support billed services.

   Explanation of benefits dated November 23, 2010
   - 16 – Documentation does not support billed services.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the requester document the time for procedure codes 97110 and 97140?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 states in pertinent part "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - CMS, Medicare Learning Network Fact Sheet states in part, "When only one service is provided in a day, a service performed for less than eight minutes should not be billed. When more than one unit of service is provided, the initial and subsequent services must total at least 15 minutes, and the last unit may be counted as a full unit of service if at least eight minutes of additional service has been furnished."
2. 28 Texas Administrative Code §134.203 states in pertinent part "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - The requestor disputed non-payment of CPT codes 97140 and 97110 for dates of service: September 21, 2010, September 23, 2010, September 24, 2010, September 28, 2010, September 30, 2010 and October 4, 2010.
   - CPT codes 97110 and 97140 are reimbursed at 15 minute increments. CMS requires that the total treatment minutes, including those minutes of active treatment reported under the timed codes and those minutes represented by the untimed codes, must be documented.
   - The requestor documented one unit of CPT code 97110, the insurance carrier paid for one unit of CPT code 97110. Therefore no additional reimbursement is recommended for CPT code 97110 for the dates of service indicated above.
   - The requestor did not document time associated with the billing of CPT code 97140, therefore reimbursement is not recommended for CPT code 97140 for the dates of service indicated above.
   - As a result, the requestor is not entitled to additional reimbursement for the disputed dates of service.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 23, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.